ELLON GROUP PRACTICE - NEW PATIENT QUESTIONNAIRE

Name: ..... **Date of Birth:** .....

Address: .....

.....

.....

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐

Have you ever been registered at Ellon Health centre before? YES/NO
Have you ever been a member of the Armed Forces? YES / NO

Telephone Number: ..... **E-Mail Address:** .....

Previous Address: .....

Occupation: ..... **Mobile No:** .....

Next of Kin: .....

Are you a Carer? ☐ Main carer for someone else? ☐ Who for? .....

Other members of household:-

Name:	**Age:**	**Relationship:**

Medical History

Previous serious illnesses: **Operations and dates:**

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ADDITIONAL INFORMATION REQUIRED – PLEASE SEE OVERLEAF

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Present Regular Medication (please list name, strength and how often taken):

Name:	**Strength:**	**How often taken:**

Drug Allergies:

Family History:

Is there anyone in your family who has had:

Heart Disease ☐ Please give details ----------

Stroke ☐ Please give details ----------

Cancer ☐ Please give details ----------

Diabetes ☐ Please give details ----------

Smoking Habits:

Smoker ☐ Number of cigarettes/cigars per day ----------

Never Smoked ☐

Ex-Smoker ☐ Date Stopped ---------- Number of cigarettes/cigars per day ----------

Alcohol Intake:

Please estimate your alcohol intake per week (1 unit = half pint beer or 1 glass wine or 1 measure spirit)

Number of units per week ----------

Current Height: ---------- **Current Weight:** ----------

Women Only: **Date of last cervical smear:**_ _ _ _ _ _ _ _ _ _ _ _ **Result:** _ _ _ _ _ _ _ _ _ _

Are you on the contraceptive pill? _ _ _ _ _ _ _ **Are you currently pregnant?** _ _ _ _ _ _ _ _

Date form completed: ---------- **Signature:** ----------